



CHIEF COMPLAINT

NEW PATIENT

Insurance

Self Pay

Work Related

ESTABLISHED PATIENT

PATIENT INFORMATION

Last Name _____ First Name _____ M _____

Date of Birth ____/____/____ Age ____ Sex M F Social Security # _____ - _____ - _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Mobile (____) _____ - _____ Preferred Home Mobile

Email _____ Race _____ Ethnicity _____ Preferred Language _____

Primary Care Physician _____ Phone (____) _____ - _____

In case of Emergency (Name, Phone, Relation) _____

Patient Employed By _____ Work Phone (____) _____ - _____

How did you hear about us? Billboard Drive By Email Facebook/Twitter Insurance Mailer Media Military School Webpage Word of Mouth

PARENT/GUARANTOR INFORMATION

Last Name _____ First Name _____ M _____

Date of Birth ____/____/____ Age ____ Sex M F Social Security # _____ - _____ - _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Mobile (____) _____ - _____ Preferred Home Mobile

Relation to Patient Parent Guardian Spouse Employer Other

PRIMARY INSURANCE

Insurance Carrier _____ Name _____ Sex M F

Subscriber ID _____ Group _____ Date of Birth ____/____/____ Relation _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

SECONDARY INSURANCE

Insurance Carrier _____ Name _____ Sex M F

Subscriber ID _____ Group _____ Date of Birth ____/____/____ Relation _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment: The administration and cost of all medical and surgical procedures, x-ray, and medication for myself and for my dependents.

Guarantee of Payment:

____ Initial SELF PAY – I elect to pay for all services rendered in full today. I understand that my insurance will **NOT** be billed by Complete Urgent Care (CUC).

____ Initial INSURANCE – **Assignment of Benefits:** I authorize payment directly to Complete Urgent Care (CUC) for all benefits otherwise payable to me. **I also acknowledge that CUC will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred.** I agree that I will pay my estimated balance today based on the best available information of my current policy and CUCs current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While CUC makes every effort to verify my correct insurance information prior to leaving, I understand CUC cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

Release of Medical Records: I authorize Complete Urgent Care (CUC) to release verbally, electronically, and/or in writing confidential medical information to any person or entity including my insurance carrier, employer (if treatment is related to employment), immediate family member (s), and/or other healthcare provider (s) for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures. I understand that should I choose not to release my medical record to a specific entity and/or person (s) I must specifically state so in writing to be kept in my medical record.

Receipt of Privacy Practices: By signing this consent form I acknowledge that a copy of the Notice of Privacy Practices of Complete Urgent Care is available to me upon request and can be downloaded at www.completeurgentcare.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Patient Signature _____ Date _____

Responsible Party _____ Date _____